

Case Number:	CM14-0112055		
Date Assigned:	08/01/2014	Date of Injury:	03/16/2011
Decision Date:	09/29/2014	UR Denial Date:	07/15/2014
Priority:	Standard	Application Received:	07/18/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 43 year old female with a 3/16/11 injury date. The mechanism of injury is not provided. In a follow-up on 7/18/14, subjective complaints were constant lower back pain radiating to the right greater than left leg, from the buttocks to the knee level. The right big toe feels constantly numb and occasionally the entire foot goes numb. These symptoms are limiting her functions and ADLs. Objective findings included lumbar flexion of 45 degrees, extension of 18 degrees, paraspinal tenderness, positive SLR on the right side at 55 degrees, decreased sensation in the right L5 and S1 distributions, symmetric reflexes, and normal gait. Lumbar spine x-rays on 9/30/13 revealed some loss of normal lumbar lordosis. An MRI of the lumbar spine on 9/30/13 showed a 4-5 mm disc herniation at L4-5 with moderate bilateral stenosis of the lateral recesses, potential impingement of the bilateral L5 nerve roots, and annular tear transverse to the L4-5 disc margin. Diagnostic impression: lumbar disc herniation, lumbar radiculopathy. Treatment to date: lumbar ESI without relief, physical therapy, medications, heating pads, home exercises. A UR decision on 7/15/14 denied the request for lumbar disc replacement vs. fusion on the basis that there is insufficient objective evidence that confirms radiculopathy and those guidelines regard disc replacement surgery as experimental at this time. The request for surgical disco gram was denied on the basis that guidelines do not support the use of this procedure as a preoperative indication for fusion. The request for post-op CT scan was denied on the basis that the primary surgical procedure was not approved.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

1 Anterior Discectomy with complete resection of the degenerative disk segment and reconstruction with an artificial disk replacement or interbody fusion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back Chapter.

Decision rationale: CA MTUS does not address the issue of artificial disc replacement. ODG states that artificial disc replacement surgery is experimental only and cannot be recommended. For lumbar fusion and decompression, CA MTUS states that surgical intervention is recommended for patients who have severe and disabling lower leg symptoms in the distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; clear clinical, imaging, and electro physiologic evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair; and failure of conservative treatment. In addition, CA MTUS states that there is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. In the present case, there is limited evidence-based support for disc replacement surgery and the procedure cannot be approved. In addition, the requested procedure as a whole cannot be approved since disc replacement is listed as part of the request. Therefore, the request for 1 Anterior Discectomy with complete resection of the degenerative disk segment and reconstruction with an artificial disk replacement or interbody fusion is not medically necessary.

1 Surgical Diskogram at L4-5 with a control level at L2-3 under sedation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back Chapter.

Decision rationale: CA MTUS states that recent studies on discography do not support its use as a preoperative indication for either intradiskal electrothermal (IDET) annuloplasty or fusion. In addition, ODG states that provocative discography is not recommended because its diagnostic accuracy remains uncertain, false-positives can occur in persons without low back pain, and its use has not been shown to improve clinical outcomes. Therefore, the request for 1 Surgical Diskogram at L4-5 with a control level at L2-3 under sedation is not medically necessary.

Post discectomy Computerized Tomography Scan under sedation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back Chapter.

Decision rationale: CA MTUS and ODG criteria for lumbar CT include lumbar spine trauma with neurological deficit; or traumatic or infectious myelopathy; or to evaluate a pars defect not identified on plain x-rays; or to evaluate successful fusion if plain x-rays do not confirm fusion. In the present case, the primary surgical procedure was not certified; therefore, the postop CT scan is not necessary. Therefore, the request for Post discectomy Computerized Tomography Scan under sedation is not medically necessary.